

GHALY NEUROSURGICAL ASSOCIATES
Patient Registration Form - MVA or W/C

Please provide your primary care physician's name (PCP):

First: _____ Last: _____
Address: _____
City/State/Zip: _____
Phone: _____

If you were referred by a physician OTHER than your PCP, please provide the following information:

First: _____ Last: _____
Address: _____
City/State/Zip: _____
Phone: _____

Workers' Compensation Coverage Insurance Information

Insurance Carrier Name: _____
Address: _____
City/State/Zip: _____
Claim #: _____
Adjuster Name: _____
Contact Phone Number: _____ Date of Injury: _____

Motor Vehicle Coverage Insurance Information -MVA

Insurance Carrier Name: _____
Address: _____
City/State/Zip: _____
Claim #: _____
Adjuster Name: _____
Contact Phone Number: _____ Date of Accident: _____

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Consents and Authorizations

Release of Information: I authorize **GHALY NEUROSURGICAL ASSOCIATES** to release to my insurance company or its representatives, information including diagnosis and the records of any treatment or examination rendered to me that they may require to process my claim for benefits.

Authorization for Assignment of Benefits: I authorize and request that my insurance company pay directly to **GHALY NEUROSURGICAL ASSOCIATES** the amount due me in pending claims for medical treatments or services, by reason of such treatments or services rendered to me. This assignment will remain in effect until revoked by me in writing.

Financial Agreement: It is understood that, whether I sign as patient or responsible party, I am directly responsible for services rendered which are not paid by insurance. I certify that to the best of my knowledge, the information contained on this Patient Registration Form is correct and true. I will notify **GHALY NEUROSURGICAL ASSOCIATES** in case of any change in the information contained on this form.

I have read and agreed to the above consents and authorizations:

Patient Name (Please Print): _____

Patient Signature: _____

Date: _____

If the patient is a MINOR, the parent or guardian should sign below:

Responsible Party (Please Print): _____

Responsible Party Signature: _____

Date: _____